Carolina Arthritis Center

Authorization for Use or Disclosure of Protected Health Information
Information Release Form

I authorize **(Name of Health Care Component or Provider)** ______________________________

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to use and/or disclose the following individually identifiable health information **(specifically describe the information to be used and/or disclosed, such as date(s) of services, types of service, level of detail to be released, origin of information, etc.)**;

- ☐ Entire Medical Record, Date(s) ______________ ☐ Lab Reports, Date(s) ______________
- ☐ Clinical Notes, Date(s) ______________ ☐ Radiology Reports, Date(s) ______________
- ☐ Other ____

For: **(Name and Birth Date of Patient)**

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To: **Carolina Arthritis Center**
2355 Hemby Lane
Greenville, NC 27834
Phone: 252-321-8474
Fax: 252-695-6177

This information will be used or disclosed for the following purpose(s):

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If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on **(expiration date or defined event)** ______________________________

I do not have to sign this authorization in order to receive treatment from Carolina Arthritis Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Carolina Arthritis Center
HIPAA Privacy Officer
2355 Hemby Lane
Greenville, NC 27834

Internal Use Only
CAC Medical Record # ______________
By:
Signature ______________ Date

Signed by:

______________________________ ______________________________
Signature of Patient of Legal Guardian — Relationship to Patient

______________________________ ______________________________
Patient's Name — Date

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Print Name of Patient or Legal Guardian